

Case Number:	CM13-0003111		
Date Assigned:	11/08/2013	Date of Injury:	08/31/2000
Decision Date:	03/12/2015	UR Denial Date:	07/01/2013
Priority:	Standard	Application Received:	07/25/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 62 year old female continues to complain of intermittent, moderate neck and peri-scapular pain stemming from a work related injury reported on 7/29/2014. Diagnoses include: neck pain; cervical degenerative disc disease; and cervical radiculopathy. Treatments have included: consultations; diagnostic imaging studies; physical therapy with cervical traction; cervical spine collar after surgery was ruled out; unremarkable neck and upper extremity electro-diagnosis (9/15/10); and medication management. The injured worker (IW) is noted to be permanent and stationary with no plan to return to work. The agreed medical evaluation, dated 2/12/13 but with evaluation date of 12/12/2012, notes the foci of this evaluation was on the multiple musculoskeletal areas examined back on 12/12/2012. Present subjective complaints noted constant centered pain, rated 5-6/10, over the mid neck, right > left, that radiated to the bilateral shoulder blades, with bilateral hand numbness and upper extremity weakness; aggravated with activity. Objective findings included right and left sided cervical paraspinal musculature/trapezius, and bilateral upper extremity carpal tunnel surgical scars (from 1999 surgeries); Bilateral upper extremity Madelung's disease with shorter than normal, right > left, forearms; and abnormal testing to the left upper extremity. The impression included: repetitive strain injury with multi-level small disc protrusion/bulging (2010 MRI) and normal bilateral upper extremities with no cervical radiculopathy (via electro-diagnostic studies 2010); and resolution of identified disc protrusion (2009) with conservative treatment, with cervical traction and physical therapy and possible left cervical injections, recommended. Maximum medical improvement of the cervical spine was reached in 6/2011. No other medical records were

available for my review. On 7/1/2013 Utilization Review non-certified, for medical necessity, a request for a functional restoration program (FRP) stating there were no specific documentation of significant objective deficits or significant functional impairments; therefore insufficient clinical documentation, or reasoning, to support referral for FRP. Cited were the ODG guidelines for FRP and ACOEM pain management guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

FUNCTIONAL RESTORATION PROGRAM: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 107 and 114. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Functional Restoration Programs

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Program, Functional Restoration Program Page(s): 30-32.

Decision rationale: The California Medical Treatment & Utilization Schedule Guidelines indicate that a Functional Restoration program is recommended for patients with conditions that put them at risk of delayed recovery. The criteria for entry into a functional restoration program includes an adequate and thorough evaluation that has been made including baseline functional testing so follow-up with the same test can note functional improvement, documentation of previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement, documentation of the patient's significant loss of the ability to function independently resulting from the chronic pain, documentation that the patient is not a candidate for surgery or other treatments would clearly be warranted, documentation of the patient having motivation to change and that they are willing to forego secondary gains including disability payments to effect this change, and negative predictors of success has been addressed. Additionally it indicates the treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. There was no clinical documentation submitted for review addressing the request and, as such, the request did not meet the criteria. The request as submitted failed to include the duration for the program and the body part to be treated. Given the above, the request for the Functional Restoration Program is not medically necessary.